Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3926

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-0543-01

MFDR Date Received
SEPTEMBER 18, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There is no evidence provided by the carrier that the disputed charges were not billed at the hospital's usual and customary rate…The fees paid by the Carrier in this case do not conform to the reimbursement section of Rule § 134.404."

Amount in Dispute: $1,100.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. There is a Focus/First Health PPO contract with the requestor; 2. The Texas Mutual audited the hospital charges per the applicable hospital facility fee guideline; 3. Because there is a PPO contract in place with the requestor a further reduction in reimbursement was made resulting in the current payment amount; and 4. For its part the requestor has not demonstrated that the reduction from the PPO is not applicable or correct. For these reasons Texas Mutual believes no further payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2008 through September 20, 2008	Inpatient Hospital Surgical Services	$1,100.54	$1,100.54

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires insurance carriers to notify health care providers about contractual agreements when processing the bills.
3. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits

- CAC-W1-Workers compensation state fee schedule adjustment.
- CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement (Use group codes PO or CO depending upon liability).
- 468-Reimbursement is based on the medical hospital inpatient prospective payment system methodology.
- 793-Reduction due to PPO contract. PPO contract was applied by Focus/First Health.
- 897-Separately reimbursement for implantables made in accordance with DWC rule chapter 134: Subchapter E-Health facility fees.
- 891-The insurance company is reducing or denying payment after reconsideration.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   Review of the documentation found supports that the following:

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278 or other disputed (b)(2) items	Sni Rod Thr 200	Thread Rod 20mm	$26.40/each X 11	$290.40	$319.44
278 or other disputed (b)(2) items	Sni Rng Ful 205	Full Ring 205mm	$733.46/each X 6	$4,400.76	$4,840.84
278 or other disputed (b)(2)	Sni Fix Bolt Slot	Bolt Wire Fix Slotted	$31.92/each X 21	$670.32	$737.35

items					
278 or other disputed (b)(2) items	Sni Bolt 16mm	Bolt 16mm	$2.64/each X 5	$13.20	$14.52
278 or other disputed (b)(2) items	Sni Nut 10mm	10mm Nut	$2.49/each X 61	$151.89	$167.08
278 or other disputed (b)(2) items	Sni Nut 4 Pt D/C	Counter 4 Point D/C	$60.00/each X 6	$360.00	$396.00
278 or other disputed (b)(2) items	Sni Socket Thr 20	Thd Socket 20mm Length	$35.40/each X 11	$389.40	$428.34
278 or other disputed (b)(2) items	Sni Socket Thr 30	Thd Socket 30mm Length	$35.40/each X 2	$70.80	$77.88
278 or other disputed (b)(2) items	Sni Wire 1.8x280	Wire Ilizarov	$39.00/each X 2	$78.00	$85.80
278 or other disputed (b)(2) items	Sni Wire Olv 1.8	Wire Ilizarov W/ Stopper	$149.85/each X 10	$1,498.50	$1,648.35
278 or other disputed (b)(2) items	Sni Bolt 12mm	12mm Bolt	$4.34/each X 22	$95.48	$105.023

$8,018.75	$8,820.63
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is 494, and that the services were provided at Texas Orthopedic Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $6,906.13. This amount multiplied by 108% results in an allowable of $7,458.62.
   - The total cost for implantables from the table above is $8,018.75. The sum of the per-billed-item add-ons does not exceed the $2000 allowed by rule; for that reason, total allowable amount for implantables is $8,018.75 plus $801.87, which equals $8,820.63.

   Therefore, the total allowable reimbursement for the services in dispute is $7,458.62 plus $8,820.63, which equals $16,279.25. The respondent issued payment in the amount of $14,968.32. The difference between the MAR and amount paid is $1,310.93. Based upon the documentation submitted, the requestor is seeking additional reimbursement in the amount of $1,100.54. This amount is recommended in additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,100.54 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/25/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.